Any Questions?

We publish below a selection of questions and answers of general interest

Disfiguring Veins on the Nose

Is there any treatment for prominent skin veins of the nose in an older person which cause disfiguration?

It is possible to obliterate a small number of disfiguring, permanently dilated skin veins either by electric cautery using a very fine needle or by "chemosurgery" with corrosive substances like 90% trichloracetic acid applied with a finely pointed orange stick. Both these techniques require an experienced operator before satisfactory results are obtained. They should not be undertaken by an enthusiastic amateur without skilled supervision. If an extensive area on the face has to be treated it is advisable to tackle first a small test area such as the nose, which is often most markedly affected and can cause great embarrassment.

Tetanus Protection

What treatment should be carried out for protection against tetanus in the following situations? (1) A patient has a clear indication for protection, but the state of his immunity is unknown; (2) A non-immunized patient has a trivial wound with little likelihood of such an infection developing.

If a patient's immunization history is not known, he must be assumed to be susceptible to tetanus and treated accordingly. If there is a clear indication for protection, the wound should be cleaned and both human tetanus immunoglobulin (250 I.U.) and aluminium adsorbed tetanus toxoid (10 Lf) should be administered. Human tetanus immunoglobulin should provide passive protection for a period of 4 to 6 weeks but is not universally available. A long-acting penicillin and-or horse antitoxin are used as substitutes, but the former gives protection for only a few days while the latter gives protection for a variable period of up to 14 days. The risks associated with the use of horse serum, however, have understandably rendered it unacceptable to most casualty units.

Approximately half of all tetanus cases occur after trivial wounds, particularly puncture wounds involving tissues which have a relatively poor blood supply. All wounds are tetanus prone and therefore a non-immunized patient with a trivial wound should be protected.

Pink Napkins

What could be the cause of a healthy 10-month-old baby's urine staining the napkins pink? It does not go with washing or soaking. The infant has had no drugs and the only change in diet has been the addition of rose hip syrup.

The first possibility to consider is that the baby is passing blood in the urine. A freshly wet napkin could be tested with Occultest or Haemastix, but it would be much better to obtain a urine specimen (the mother could almost certainly catch one, but alternatively a plastic collection bag could be used) and examine it for red cells. If blood is found in the urine there may be a local cause of bleeding in the external genitalia, but this would probably already have been noticed. Other causes of haematuria in childhood have also been described,[1] and the baby would certainly require further investigation.

If the coloration is not due to blood some less likely possibilities should be considered. The rare erythropoietic form of porphyria often first presents with the passage of red urine: the urine should therefore be examined for porphyrins. A condition has been described in which a baby's stool contained the chromobacterium *Serratia marescens*, and this produced a red pigment in the napkins when they had been kept at room temperature for 24-36 hours. (The napkins were not red immediately after urine had been passed). It would therefore be of interest to culture the baby's stool.

It is well known that in older children certain coloured sweets and drinks can lead to red discoloration of the urine. I have not heard of this happening in babies given any of the usual brands of rose hip syrup, but if the red discoloration is a constant phenomenon it would be reasonable to omit the rose hip syrup from the diet for, say, a week to see if the pink staining stops.

Cone[2] has composed a most useful list of conditions associated with abnormal coloration of the urine or napkin.

[1] *British Medical Journal*, 1970, **2**, 678.
[2] Cone, T. E., *Pediatrics*, 1968, **41**, 654.

Notes and Comments

Susceptibility to Infection after Vaccination.—Dr. W. EHRENGUT (Hamburg, Germany) writes: In the answer to this question ("Any Questions?" 23 October, p. 226) your Expert discussed whether the risk of contracting a fatal infection would be greater after smallpox vaccination than in unvaccinated children. We can support the opinion of your Expert with some studies we have made.[1-3] During convalescence from poliomyelitis susceptibility to other infections is not increased. A similar situation obtains after oral polio immunization (with attenuated viruses). A mass polio immunization programme in Bavaria gave us the opportunity to investigate this matter.[3] In the years 1962 to 1964 among 702,348 individuals vaccinated in the Bavarian campaign there were 26 deaths due to intercurrent infections (pneumonia, purulent meningitis, etc.), with only one death among 27,013 children under three years of age within 4 weeks following their polio vaccination. In the same period 510,551 children of the same age group had had primary vaccination against smallpox. Necropsy records showed 18 fatal cases due to various causes (1 death per 28,363) after smallpox vaccination. Poliomyelitis or postvaccinial encephalopathy were excluded. We therefore concluded that during mass immunizations some fatalities unconnected with the immunizations are to be expected statistically and and the figures suggest that poliomyelitis itself does not lower the susceptibility to other infections.

[1] Ehrengut, W., Mai, K., and von Mutzenbecher, H., *Deutsche Medizinische Wochenschrift*, 1965, **91**, 2339.
[2] Ehrengut, W., and Ehrengut-Lange, J., *Münchener Medizinische Wochenschrift*, 1968, **110**, 2291.
[3] Ehrengut, W., and Ehrengut-Lange, J., *Münchener Medizinische Wochenschrift*, 1969, **111**, 1092.